Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net.
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1 A summary of our inspection

About the service we inspected
Surehaven is a 21 bed low secure psychiatric hospital in Drumchapel, on the outskirts of Glasgow. The hospital provides care and treatment for patients with a primary diagnosis of mental disorder, including psychosis, personality disorders, challenging behaviours, mild learning disabilities and patients with a forensic history. The hospital also provides care and treatment for patients who may be liable to be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

About our inspection
This inspection report and grades are our assessment of the quality of how the service was performing in the areas we examined during this inspection.

Grades may change after this inspection due to other regulatory activity, for example if we have to take enforcement action to improve the service or if we investigate and agree with a complaint someone makes about the service.

We carried out an unannounced inspection to Surehaven Hospital on Tuesday 28th and Wednesday 29th June 2016.

The inspection team was made up of three inspectors and a public partner. A key part of the role of the public partner is to talk to patients and relatives and listen to what is important to them.

We assessed the service against five quality themes related to the Healthcare Improvement Scotland (Requirements as to Independent Healthcare Services) Regulations 2011 and the National Care Standards. We also considered the Regulatory Support Assessment (RSA). We use this information when deciding the frequency of inspection and the number of quality statements we inspect.

Based on the findings of this inspection, this service has been awarded the following grades:

Quality Theme 0 – Quality of information: 4 - Good
Quality Theme 1 – Quality of care and support: 4 - Good
Quality Theme 2 – Quality of environment: 2 - Weak
Quality Theme 3 – Quality of staffing: 4 - Good
Quality Theme 4 – Quality of management and leadership: 5 - Very good

The grading history for Surehaven Hospital can be found on our website.

Before the inspection, we reviewed information about the service. During the inspection, we gathered information from a variety of sources. We spoke with a number of people during the inspection.

What the service did well
The service provided a variety of opportunities for patients and carers to get involved in assessing and improving the service. Patient care records showed that the service had comprehensive and clear care plans in place to help patients address any issues of mental health. It also had very good systems in place to ensure that all the patients were supported with the least restrictive options in mental health where possible.
What the service could do better

The service must improve the current standard of cleanliness and infection prevention. The staff should also consider additional strategies to manage specific patient behaviours, which increase the risks associated with the spread of infection.

This inspection resulted in five requirements and 10 recommendations. The requirements are linked to compliance with the Act and regulations or orders made under the Act, or a condition of registration. See Appendix 1 for a full list of the requirements and recommendations.

Surehaven Glasgow Ltd, the provider, must address the requirements and make the necessary improvements as a matter of priority.

We would like to thank all staff at Surehaven Hospital for their assistance during the inspection.
2 Progress since our last inspection

What the service had done to meet the recommendations we made at our last inspection on 15 and 16 October 2014

Recommendation

*We recommend that the service should include more specific information for patients in written form and on the website about rights and responsibilities. This should include smoking arrangements, the list of contraband items and mobile phones.*

**Action taken**

This recommendation is reported under Quality Statement 0.2. *This recommendation is not met* (see recommendation a).

Recommendation

*We recommend that the service should review the medication policy and practice in relation to inspection of medication storage areas and who is responsible for this.*

**Action taken**

The service has allocated a named nurse to take responsibility for each medication storage area. *This recommendation is met.*

Recommendation

*We recommend that the service should ensure storage areas are audited to ensure unused medications are returned or disposed of safely.*

**Action taken**

This recommendation is reported under Quality Statement 1.4. *This recommendation is not met* (see recommendation c).

Recommendation

*We recommend that the service should ensure recording of medication administration and medication incidents is specifically monitored to recognise trends and inform the governance of medication management.*

**Action taken**

The consultant psychiatrist and pharmacist meet monthly. Trends are discussed and identified at this meeting. *This recommendation is met.*
Recommendation

We recommend that the service should ensure the environment and equipment are maintained in good order and a maintenance plan implemented to address the issues identified with paintwork, equipment and bathrooms.

Action taken

This recommendation is reported under Quality Statement 2.2. This recommendation is not met (see requirement 4).
3 What we found during this inspection

Quality Theme 0 – Quality of information

Quality Statement 0.2
We provide full information on the services offered to current and prospective service users. The information will help service users to decide whether our service can meet their individual needs.

Grade awarded for this statement: 4 - Good
The service’s website was written in plain English with several downloadable publications for potential patients and carers. The service could access interpreters’ services for patients whose first language was not English. The service also had access to communication assistance equipment.

The service stated clearly on its website that patients and carers could complain to its regulator, Healthcare Improvement Scotland, at any time.

Advocacy services information was displayed throughout the service and we saw posters showing how the service had acted on patients suggestions. Staff told us that during pre-admission visits they explain to patients how they can access therapies, inform them about prohibited items and highlight local advocacy services.

Patient care plans showed the service had a very good awareness of the emotional and psychological concerns that patients may have when being detained under The Mental Health (Care and Treatment) (Scotland) Act 2003. It provided clear evidence of how it proposed to support patients to overcome these concerns.

Area for improvement
We spoke with senior staff about including information on prohibited items on the service’s website, to help promote a culture of safety for patients and staff (see recommendation a).

- No requirements.

Recommendation a
- We recommend that the service should amend its website to make clear to prospective patients and carers that there may be some items which will not be allowed in the service because of safety concerns.

Quality Statement 0.3
We ensure our consent to care and treatment practice reflects Best Practice Statements (BPS) and current legislation (where appropriate Scottish legislation).

Grade awarded for this statement: 5 - Very good
We looked at eight patient care records. They showed that all patients were either detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995. They also showed the service had actively encouraged each patient to have a named person to look after their best interests. This named person was usually a family member or friend. The majority of patient records contained an advance
statement which demonstrated that they were well enough to say how they wish to be treated if they become unwell.

The service used the appropriate forms when care planning for patients. Some forms relied on patient’s informed consent. Other forms relied on a doctor writing a patient’s care plan because the patient was deemed as not having the capacity to participate in the care planning process. We saw evidence that all patients had the appropriate forms in place, review dates were recorded and records were stored in a secure cupboard.

The service encouraged patients to help manage their own financial matters. We saw that some patients had received help in this area and that safeguards to protect the patient were in place.

The service had a process in place to advise patients of right of appeal through the advocacy service. In order to appeal, patients can make representations to:

- an advocate
- a lawyer
- a member of parliament, and
- their named person.

We saw very good evidence that the service followed the principles of mental health care and treatment. A weekly care planning approach meeting considered the wishes of the multidisciplinary team and the patient. A process was in place to allow temporary leave for patients, either on their own or accompanied by staff. Such leave was considered on an individually following a risk assessment

Areas for improvement
Staff described the difficulties they often have when balancing the management of challenging and complex behaviour with supporting the rights and choices of individual patients. The service could investigate further strategies that would help the management of these two issues.

- No requirements.
- No recommendations.

Quality Theme 1 – Quality of care and support

Quality Statement 1.1
We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Grade awarded for this statement: 5 - Very good
The service’s participation policy explained how staff could engage with service users. The policy included examples of strategies to help make sure patients and carers were actively involved in assessing and improving the service. We saw a range of evidence that showed how patient and carer views were gathered used to develop the service.

Patients were invited to join the community meetings group. A member of staff and a patient facilitated the group. The group aimed to support patients to share their views about the
service and discuss possible improvements. Staff listened to patient concerns and where possible, the group tried to identify ways to promote greater satisfaction. Staff completed a group evaluation form, which was reviewed at the next meeting. Some patient suggestions that had been implemented included:

- One patient liked to listen to music and played it loudly when upset. Staff suggested they wear earphones so they could listen to music loudly without bothering others.
- Some patients wanted to do more activities in the community. Staff listened to their suggestions and increased community walks.
- The service had started to develop an allotment so patients could spend more time outside.

During our visit, we spoke with some patients and carers. They told us:

- ‘It’s wonderful, the staff are friendly. My son loves it here and gets lots of attention from staff.’
- ‘I feel I have come a long way here. It’s the best hospital I have been in.’

From the service’s completed patient satisfaction questionnaires we reviewed, most patients were very happy with the quality of care. No patients stated they were unsatisfied with their care.

When another professional, such as a dentist or optician cared for a patient, the patient was given an ‘External Services Satisfaction Questionnaire’ to complete. Patients who competed the questionnaires were satisfied with their care.

Every patient had a named person who acted as a guardian for the patient. The service kept named persons informed about patient wellbeing, in line with good practice. Named persons were asked to complete feedback questionnaire about the quality of information they received from the service. Most named persons who completed the questionnaire were happy with the information. Some said they would have liked more information about the service and suggested ways to do this.

We also reviewed responses to the most recent carers questionnaire. This questionnaire was given to all carers and relatives of patients being cared for in the service. Responses to this questionnaire showed that carers were very happy with the quality of information and care their relative received. Comments included:

- ‘The staff go out of their way to make me feel welcome and involved in the care plan. They put the care of patients first and are happy to support them in any way possible.’
- ‘From a personal point of view, we have always been treated with the utmost respect and patience when visiting my son.’

**Areas for improvement**

The service’s website and patient and carer welcome leaflets summarised the service and how patient needs will be met. The service could include information about how patients and carers can help staff evaluate the quality of care on its website and leaflets.

Staff used the same patient evaluation questionnaire each time. They could consider changing the questions asked so different aspects of the service’s care could be evaluated in more detail.
Although we saw some evidence to demonstrate how patient’s suggestions had been implemented, this was not consistent. Staff responded to some patient questions and ideas with examples of what was already done rather than what could be done. The staff could consider offering more suitable responses to ensure patients understand why certain ideas cannot be implemented.

- No requirements.
- No recommendations.

Quality Statement 1.4

We are confident that within our service, all medication is managed during the service user’s journey to maximise the benefits and minimise any risk. Medicines management is supported by legislation relating to medicine (where appropriate Scottish legislation) and current best practice.

Grade awarded for this statement: 4 - Good

The service had a comprehensive policy which covered administration of medications. This could mean controlled drugs, rapid tranquilisation and patient-specific requirements. The service administered and kept medication in two separate areas; one in each ward. Each ward had a nurse responsible for medications. All stock we examined was in date in both wards. Temperatures of medicine refrigerators were being recorded daily. Instructions on what to do if the temperature measured was outside the acceptable range were in place. Controlled drug books were up to date and accurate. Any errors made had been addressed correctly.

Staff who administer medication had their practice observed twice a year. Patients’ medication was discussed and amended at monthly meetings held between the consultant psychiatrist and the pharmacist. Medication was also discussed at weekly meetings. The pharmacist carried out a service review every 3 months.

Timetables were in place and results recorded for any patient prescribed a medication which required to be closely monitored.

We saw evidence that medication administration audits were being carried out monthly.

Areas for improvement

The medicines management documentation did not have enough space to fully record the service’s medicines reconciliation process.

We could see that patient details and allergy status were being recorded on the prescription and administration record. A record of medications a patient had brought in was kept in their own drugs record. However, the forms had no space to record the second source of obtaining the patient’s medicines history. The form also did not have space for the person carrying out the medicines reconciliation to sign (see recommendation b).

The medication administration area in Campsie ward was cluttered. We saw opened tubes of cream which had not been allocated to a patient. The service had a surplus of methadone for a patient who had moved on to individual doses. We saw a container of opened boxes of nicotine-replacement therapy medication, which made it difficult to identify which box belonged to which patient (see recommendation c).
- No requirements.

**Recommendation b**

- We recommend that the service should review its medicines admission documentation and implement comprehensive recording of medicines reconciliation that meets the guidance set out in the guidance Safer Use of Medicines: Medicines Reconciliation SGHD/CMO (2013). This information should also be incorporated into the service’s procedure for the management of medicines.

**Recommendation c**

- We recommend that the service should implement a system of auditing medicine storage areas to provide assurance that individual patient’s medications can be easily identified and unused medications are being returned or disposed of safely.

**Quality Theme 2 – Quality of environment**

**Quality Statement 2.2**

>We are confident that the design, layout and facilities of our service support the safe and effective delivery of care and treatment.

**Grade awarded for this statement: 2 - Weak**

Patients at the service were being cared for in one of two secure, gender specific wards. A 10 bed female ward (Campsie) was on the ground floor and an 11 bed male ward (Kelvin) on the first floor.

Every patient had their own bedroom, with ensuite toilet and shower facilities. Patients told us they liked being able to personalise their own rooms. An alarm system linked the bedrooms to each ward’s nurses station and another alarm system so staff could respond quickly. Each ward had its own:

- activity room
- dining room
- lounge
- quiet room, and
- therapy kitchen.

The service had a central secure courtyard, garden and smoking area outside. Patients could access the smoking area if it had been risk-assessed as being appropriate. The courtyard had two areas; one for males and another for females. Patients also used a barbecue area in the courtyard during summer.

The car park at the front of the building was tidy, had sufficient parking space and was surrounded by well-maintained lawns.
Areas for improvement

Both wards were not cleaned to an acceptable standard. The majority of walls and floors were stained and the environment did not smell fresh. The dining rooms on both wards had food debris on the floor and the refrigerators in these areas had dirty and damaged seals.

One patient bathroom floor covering on Kelvin ward was heavily stained with body fluid residue (see requirement 1).

Cleaning staff told us the type of materials covering the floors and walls made them difficult to clean. They also told us that, due to some patient’s mental state, it often took several days before some patient bedrooms could be accessed to clean them. Recent minutes of the health and safety and infection control committee referred to reports from cleaning staff of difficulties getting into patient bedrooms to clean. We saw no evidence that this had been addressed. The service must review of how it carries out cleaning duties, to make sure the environment can be kept clean at all times (see requirement 2).

Most patient bedrooms were very cluttered. We saw that patient belongings were stored on the floor and on top of units in bedrooms, making it difficult to clean the rooms to an acceptable standard. The service should consider providing additional storage in patient bedrooms (see recommendation d).

With one exception, all patient bedrooms had carpets. Carpets throughout the service were badly stained, sticky and smelled unpleasant. We spoke with senior staff about providing more appropriate floor coverings that could be kept clean more effectively (see requirement 3).

Each ward had a dedicated treatment room. However, the treatment room on Campsie ward had stained and peeling surfaces and needed to be refurbished (see recommendation e).

We found three rooms not on wards which could be improved:

- Therapy room 1 was currently being used as a storage room. However, it had recently also been used as a patient gym and gym. This room was no longer being used as a gym but the gym equipment remained in place.
- The GP room was multi-purpose and during our inspection it was being used as a massage room. Some curtains were missing and bed sheets had been used to replace them.
- The staff changing area and shower room was dirty, untidy and did not have shelving to store shower products.

We discussed the use of these rooms with senior staff and agreed that they needed to be reorganised and kept clean and tidy (see recommendation f).

Requirement 1 – Timescale: by 30 August 2016

- The provider must remove and replace the heavily stained bathroom floor covering in the patient bedroom of Kelvin ward and thereafter maintain the floor covering it in clean condition.

Requirement 2 – Timescale: by 30 August 2016

- The provider must review the cleaning procedures in the service and make the necessary changes to ensure that ward areas and patient bedrooms are cleaned effectively and kept in clean condition.
Requirement 3 – Timescale: by 30 September 2016

■ The provider must investigate the most appropriate types of floor covering for the service’s ward areas and bedrooms. The floor covering must be able to be effectively cleaned and maintained. Thereafter, the provider must develop and implement a suitable and sufficient programme of work to replace all floor coverings as appropriate.

Recommendation d

■ We recommend that the service should provide additional storage in bedrooms for patient’s belongings, allowing floors to be cleaned more effectively.

Recommendation e

■ We recommend that the service should refurbish the treatment room in Campsie ward.

Recommendation f

■ We recommend that the service should tidy and reorganise treatment room 1, the GP room and the staff shower area, to provide inviting areas that are clean, tidy and well maintained.

Quality Statement 2.3
We ensure that all our clinical and non-clinical equipment within our service is regularly checked and maintained.

Grade awarded for this statement: 4 - Good

We saw records demonstrating that clinical and non-clinical equipment within the service was being serviced and maintained appropriately, for example fire detection, gas and water storage and distribution systems and the passenger lift.

The service had a fire detection system with a fire sprinkler system and alarm. All checks were up to date and appropriate maintenance was in place. We looked at the most recent Scottish Fire and Rescue Service inspection report. All recommendations had been acted on and the next inspection was due very soon. Staff had been trained in fire evacuation and regular fire drills had been recorded. Each patient had their own fire evacuation plan.

An external specialist company was managing water safety for the service. This company carried out regular checks, drained and cleaned water storage tanks and took regular samples to check for legionella bacteria in the water supply. There was an in-house maintenance assistant who was responsible for day-to-day checks, such as routine cleaning of showerheads and monitoring water temperatures.

Areas for improvement

A full-time maintenance assistant carried out most of the service’s routine repairs and redecoration. The maintenance assistant told us walls had to be regularly re-painted because patients threw food and drink at them. The type of paint the service used could not be wiped clean, meaning that contaminated walls had to be re-painted rather than cleaned. The service should consider using wipe-clean paint on walls so that surfaces can be cleaned effectively (see recommendation g).
Kelvin ward had several fire doors missing. Staff told us that patients had damaged doors beyond repair. The Scottish Fire and Rescue Service’s 2015 inspection report had also highlighted this as an issue. Recent minutes of the health and safety and infection control committee referred to ‘missing doors ongoing’. Senior staff told us they were trying to source better doors that met the service’s requirements.

The service did not have a formalised refurbishment policy and programme in place. We previously raised this during our October 2014 inspection. The service must be able to provide assurance that the maintenance, repairs and refurbishment of its facilities are carried out regularly, effectively and according to current legislation and standards (see requirement 4).

When we spoke with the maintenance assistant, they described their typical day. Many of the tasks they carried out appeared to be decided informally at the time, rather than planned ahead. More structure could be added to the maintenance assistant role, to provide a more efficient maintenance service. The development of a formalised refurbishment policy and programme would also strengthen the maintenance assistant role.

Requirement 4 – Timescale: by 30 September 2016

- The provider must develop and implement a suitable and sufficient refurbishment programme for the service. This will enable the forward planning of all repairs, refurbishment, redecoration and maintenance work.

Recommendation g

- We recommend that the service should use wipe-clean paint for future redecoration of all ward wall surfaces so they can be effectively cleaned.

Quality Theme 3 – Quality of staffing

### Quality Statement 3.2

We are confident that our staff have been recruited and inducted, in a safe and robust manner to protect service users and staff.

Grade awarded for this statement: 5 - Very good

We looked at the service’s recruitment policy and procedures. Some of the recruitment information we saw was held on an electronic system and some was in paper format in staff personnel files. Staff recruitment procedures included checks on:

- criminal records
- employment gaps
- interview notes
- qualifications
- references
- registration with professional bodies, and
- skills and experience.

We were also told that patients were involved in the interview process. All the files we checked were comprehensive and well ordered.
The new staff induction programme included fire safety, health and safety, infection control and safeguarding among other topics. While we saw some gaps in induction training completion, most of these were due to staff leave or sickness absence. We were told the service used a mentor system to help induct all new staff. Staff completed mandatory update training yearly, to make sure skills were kept up to date.

The service had a system of yearly staff appraisals. This process included self-assessment of staff’s own performance compared with the previous year. A personal development plan was then agreed for the coming year.

A staff exit survey was used when staff left their employment with the service. We examined two staff exit surveys that had been completed recently. There were many positive comments in these surveys and both respondents made reference to working in a great team.

**Areas for improvement**

The minimum staffing levels for both wards combined was:

- four qualified nurses during the day
- six unqualified staff during the day
- two qualified nurses at night, and
- four unqualified staff at night.

Extra staff resources came from overtime, bank or agency staff. The service was currently experiencing a challenge in recruiting unqualified staff because some staff had recently left or were leaving to pursue nursing qualifications. The senior management team were reviewing staff recruitment at the time of our inspection.

Surehaven Glasgow Ltd, the provider, carried out an internal quality audit of the service in 2015. This audit identified that the service did not keep induction training records for agency staff.

We examined two recently completed staff exit surveys. Both respondents answered that ‘low staffing’ was ‘the worst features of working for the service’. Some staff we spoke with said the service could feel short-staffed at times when patients are unsettled.

Patients we spoke with told us their ward did not always have enough staff and that a lot of agency staff had been used recently. They told us they felt stressed about this because agency staff were unfamiliar to them and not trained in mental health. Some patients also told us that sometimes agency staff were not always alert during one-to-one observation periods with them. We did not observe this during our inspection but we informed the senior management team, who advised they would carry out regular observations of agency staff practice.

There was a member of nursing staff responsible for infection prevention and control in the service. This post holder had not completed any specific training to help make them able to carry out this role effectively (see recommendation h).

- No requirements.
Recommendation h

■ We recommend that the service should provide infection prevention and control training for the infection control lead post holder. This will also help to improve the ongoing issues with cleaning and maintaining a clean environment.

Quality Statement 3.3
We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Grade awarded for this statement: 4 - Good

Direct observation and mentorship was used to assess staff practice. Staff told us they were offered regular meetings with their manager to discuss strengths and weaknesses and ways to improve their skills. More detailed meetings between staff and their manager were held yearly.

Staff told us they enjoyed working in the service and were given plenty of opportunities to develop their knowledge and skills. Staff completed mandatory training, which helped them manage the types of risks present in a low-secure psychiatric setting. Staff could also complete extra training to help develop the service and their own interests. Four support workers were about to start university nursing studies to become qualified staff nurses. Senior managers supported staff to progress in their career. Extra funds were made available for staff where possible, to complete post-graduate qualifications.

We spoke with a number of people working in the service during our inspection. Staff discussed their roles and responsibilities and explained how they supported patient needs. They told us they felt respected, trusted and treated equally as important as everyone else. One staff member we spoke with said:

• ‘…can’t think of anywhere else I’d rather work.’

The cook told us:

• ‘You need to make sure patients get the kind of food they like to eat but you also need to try to include healthy ingredients to ensure they get a balanced diet. We ask patients what they like and do our best to accommodate this.’

Care staff told us how they followed national legislation and best practice guidance to make sure risks were minimised. For example, staff explained how they encouraged patients to respect each other, which helped to develop friendships in the service and a better understanding of each person’s condition.

The deputy manager, charge nurse and doctor told us how they supported each patient’s needs and managed more challenging situations. This demonstrated how staff worked as a team to minimise risks to staff and other patients.

Areas for improvement

Some of the staff we spoke with told us it was often difficult to keep the environment clean because of the impact of patients’ challenging behaviours. We spoke with senior managers about how they managed patients challenging behaviours. We also reviewed patient care plans that staff had implemented to help manage and evaluate patient’s personal hygiene.
Care plans we reviewed did not have enough detail about:

- how personal hygiene should be managed, and
- the interventions that should be used to promote the patient’s level of understanding and independence in relation to their personal care

We discussed other behaviour management strategies to minimise risks associated with the spread of infection in the service. We also discussed the need to provide more detailed information in care plans (see requirement 5).

**Requirement 5 – Timescale: by 30 August 2016**

- The provider must ensure staff develop and implement suitable and sufficient strategies to promote patient personal hygiene and review them regularly to check they are working.
- No recommendations.

**Quality Theme 4 – Quality of management and leadership**

**Quality Statement 4.3**

To encourage good quality care, we promote leadership values throughout our workforce.

**Grade awarded for this statement: 5 - Very good**

The service encouraged leadership values in various ways. Staff were encouraged to shadow and learn the role of their supervisor or line manager. This was helpful if they were asked to act up in a more senior role. When this happened, targeted training was given as support. Staff we spoke with told us they had regular supervision and that opportunities for training in the service were good. We saw evidence of this in staff records.

Staff told us they felt valued and team communication was good. They also told us the service had a collaborative approach to problem solving, with line management.

All staff could attend multidisciplinary team meetings. We found good evidence to show that staff were being asked to take leadership roles in championing particular topics. These included:

- health and safety
- infection control
- smoking cessation, and
- training.

**Area for improvement**

Staff told us they had not completed a staff satisfaction survey recently. The service should carry out yearly staff satisfaction surveys (see recommendation i).

- No requirements.
Recommendation i

- We recommend that the service should carry out yearly staff satisfaction surveys, including the development of action plans to address any findings.

Quality Statement 4.4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Grade awarded for this statement: 4 - Good

The service submitted a basic self-assessment to Healthcare Improvement Scotland. The service completes a self-assessment each year and provides a measure of how it has assessed itself against the quality themes and national care standards. We found some information that we were able to verify during our inspection. However, much of it was difficult to find and could have been more readily available.

During the inspection, we found evidence of a comprehensive system of audits. The audits covered patients’ rights and the associated issues with a direct impact on their care and treatment. This included:

- consent to treatment
- individual patient risk assessments
- patients’ right of appeal, and
- the use of medication.

We saw clinical governance meeting minutes and care programme approach meeting minutes that showed audits were carried out regularly and in the timescales stipulated by the service.

We saw records of monthly ward audits which had been carried out. These looked at:

- care plan evaluations
- clinical notes, and
- medication administration and recording systems.

A risk register was in place with a robust risk matrix. Each area in the risk matrix was colour-coded to show the severity of the risk. Each risk area had a named person to take the lead.

The service had administration policies and procedures, which covered:

- care and treatment
- the environment
- finances
- patient outings, and
- staffing.

We looked at the complaints log and found all complaints were recorded appropriately and signed by the patient or their representative. Complaints that had been made had been
investigated in satisfactory timescales and by someone independent of the complaint focus. An investigation report had been completed each time and the outcome recorded.

Monthly incident audits were being carried out. The outcome of these audits showed a high number of challenging behaviours.

The service has a weekly community meeting. We saw minutes of these meetings, along with evidence of an audit showing how the service had sought the views of external services associated or involved with the hospital.

**Area for improvement**

The service carried out a comprehensive programme of audits regularly. However, we found limited evidence of action plans being created and carried out. Environmental and cleaning issues we observed during the inspection highlighted the lack of action plans. The service should evaluate the results of audits carried out and create action plans to resolve any issues uncovered (see recommendation j).

- No requirements.

**Recommendation j**

- We recommend that the service should develop action plans following audits and ensure that findings are formally actioned and recorded.
Appendix 1 – Requirements and recommendations

The actions that Healthcare Improvement Scotland expects the independent healthcare service to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of an independent healthcare provider to comply with the Act, regulations or a condition of registration. Where there are breaches of the Act, regulations, or conditions, a requirement must be made. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.

- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

### Quality Statement 0.2

<table>
<thead>
<tr>
<th>Requirements</th>
<th>None</th>
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</table>

**Recommendation**

**We recommend that the service should:**

- **a** amend its website to make clear to prospective patients and carers that there may be some items which will not be allowed in the service because of safety concerns (see page 8).

  National Care Standards – Independent Hospitals (Standard 27.1 – Making choices and understanding your rights)

### Quality Statement 1.4

<table>
<thead>
<tr>
<th>Requirement</th>
<th>None</th>
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**Recommendations**

**We recommend that the service should**

- **b** review its medicines admission documentation and implement comprehensive recording of medicines reconciliation that meets the guidance set out in the guidance Safer Use of Medicines: Medicines Reconciliation SGHD/CMO (2013). This information should also be incorporated into the service’s procedure for the management of medicines (see page 12).

  National Care Standards – Independent Hospitals (Standard) 20.1 Medicines management.
Quality Statement 1.4 (continued)

**c** implement a system of auditing medicine storage areas to provide assurance that individual patient’s medications can be easily identified and unused medications are being returned or disposed of safely (see page 12).

National Care Standards – Independent Hospitals (Standard) 20.1 Medicines management.

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Quality Statement 2.2

**Requirements**

The provider must:

1. remove and replace the heavily stained bathroom floor covering in the patient bedroom of Kelvin ward and thereafter maintain the floor covering in clean condition (see page 13).

   Timescale – by 30 September 2016

   *Regulation 3(d)(i)*
   *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*


2. review the cleaning procedures in the service and make the necessary changes to ensure that ward areas and patient bedrooms are cleaned effectively and kept in clean condition (see page 13).

   Timescale – by 30 August 2016

   *Regulation 3(d)(i)*
   *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*


3. investigate the most appropriate types of floor covering for the service’s ward areas and bedrooms. The floor covering must be able to be effectively cleaned and maintained. Thereafter, the provider must develop and implement a suitable and sufficient programme of work to replace all floor coverings as appropriate (see page 14).

   Timescale – by 30 September 2016

   *Regulation 10(b)*
   *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

   National Care Standards – Independent Hospitals (Standard 15 – Your environment).
**Quality Statement 2.2 (continued)**

**Recommendations**

**We recommend that the service should:**

<table>
<thead>
<tr>
<th>d</th>
<th>provide additional storage in bedrooms for patient’s belongings, allowing floors to be cleaned more effectively (see page 14).</th>
</tr>
</thead>
<tbody>
<tr>
<td>e</td>
<td>include the refurbishment of the treatment room in Campsie ward in a formal refurbishment programme (see page 14).</td>
</tr>
<tr>
<td>f</td>
<td>tidy and reorganise treatment room 1, the GP room and the staff shower area, to provide inviting areas that are clean, tidy and well maintained (see page 14).</td>
</tr>
</tbody>
</table>

**National Care Standards – Independent Hospitals (Standard 15 – Your environment).**

**Quality Statement 2.3**

**Requirement**

**The provider must:**

4 develop and implement a suitable and sufficient refurbishment programme for the service. This will enable the forward planning of all repairs, refurbishment, redecoration and maintenance work (see page 15).

**Timescale** – by 30 September 2016

This was previously identified as a recommendation in our last inspection report for Surehaven Hospital.

*Regulation 10(b)*

*The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

**National Care Standards – Independent Hospitals (Standard 15 – Your environment).**

**Recommendation**

**We recommend that the service should:**

| g | use wipe-clean paint for future redecoration of all ward wall surfaces so they can be effectively cleaned (see page 15). |

**National Care Standards – Independent Hospitals (Standard 15 – Your environment).**
## Quality Statement 3.2

### Requirements

| None |

### Recommendations

**We recommend that the service should:**

- **h** provide infection prevention and control training for the infection control lead post holder. This will also help to improve the ongoing issues with cleaning and maintaining a clean environment (see page 17).

  National Care Standards – Hospice Care (Standard 10.7 – Staff)

## Quality Statement 3.3

### Requirement

**The provider must:**

5. ensure staff develop and implement suitable and sufficient strategies to promote patient personal hygiene and review them regularly to check they are working (see page 18).

- **Timescale** – by 30 August 2016

  *Regulation 3(a)*  
  *The Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011*

  National Care Standards – Independent Hospitals (Standard 15 – Your environment).

### Recommendations

| None |

## Quality Statement 4.3

### Requirements

| None |

### Recommendation

**We recommend that the service should:**

- **i** carry out yearly staff satisfaction surveys, including the development of action plans to address any findings (see page 19).

  National Care Standards – Independent Hospitals (Standard 10.9 Staff).
<table>
<thead>
<tr>
<th>Quality Statement 4.4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td><strong>We recommend that the service should:</strong></td>
</tr>
<tr>
<td>j develop action plans following audits and ensure that findings are formally actioned and recorded (see page 20).</td>
</tr>
</tbody>
</table>

National Care Standards – Independent Hospitals (Standard 10.9 Staff)
Appendix 2 – Who we are and what we do

Healthcare Improvement Scotland was established in April 2011. Part of our role is to undertake inspections of independent healthcare services across Scotland. We are also responsible for the registration and regulation of independent healthcare services.

Our inspectors check independent healthcare services regularly to make sure that they are complying with necessary standards and regulations. They do this by carrying out assessments and inspections. These inspections may be announced or unannounced. We use an open and transparent method for inspecting, using standardised processes and documentation. Please see Appendix 5 for details of our inspection process.

Our work reflects the following legislation and guidelines:

- the National Health Service (Scotland) Act 1978 (we call this ‘the Act’ in the rest of the report),
- the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011, and
- the National Care Standards, which set out standards of care that people should be able to expect to receive from a care service. The Scottish Government publishes copies of the National Care Standards online at: www.scotland.gov.uk

This means that when we inspect an independent healthcare service, we make sure it meets the requirements of the Act and the associated regulations. We also take into account the National Care Standards that apply to the service. If we find a service is not meeting the requirements of the Act, we have powers to require the service to improve.

Our philosophy

We will:

- work to ensure that patients are at the heart of everything we do
- measure things that are important to patients
- are firm, but fair
- have members of the public on our inspection teams
- ensure our staff are trained properly
- tell people what we are doing and explain why we are doing it
- treat everyone fairly and equally, respecting their rights
- take action when there are serious risks to people using the hospitals and services we inspect
- if necessary, inspect hospitals and services again after we have reported the findings
- check to make sure our work is making hospitals and services cleaner and safer
- publish reports on our inspection findings which are always available to the public online (and in a range of formats on request), and
- listen to your concerns and use them to inform our inspections.
Complaints

If you would like to raise a concern or complaint about an independent healthcare service, we suggest you contact the service directly in the first instance. If you remain unhappy following their response, please contact us. However, you can complain directly to us about an independent healthcare service without first contacting the service. Our contact details are:

Healthcare Improvement Scotland
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Telephone: 0131 623 4300
Email: comments.his@nhs.net
Appendix 3 – How our inspection process works

Inspection is part of the regulatory process.

Each independent healthcare service completes an online self-assessment and provides supporting evidence. The self-assessment focuses on five quality themes:

- **Quality Theme 0 – Quality of information:** this is how the service looks after information and manages record-keeping safely. It also includes information given to people to allow them to decide whether to use the service and if it meets their needs.
- **Quality Theme 1 – Quality of care and support:** how the service meets the needs of each individual in its care.
- **Quality Theme 2 – Quality of environment:** the environment within the service.
- **Quality Theme 3 – Quality of staffing:** the quality of the care staff, including their qualifications and training.
- **Quality Theme 4 – Quality of management and leadership:** how the service is managed and how it develops to meet the needs of the people it cares for.

We assess performance by considering the self-assessment, complaints, notifications of events and any enforcement activity. We inspect the service to validate this information and discuss related issues.

The complete inspection process is described in Appendix 5.

**Types of inspections**

Inspections may be announced or unannounced and will involve physical inspection of the clinical areas, and interviews with staff and patients. We will publish a written report 8 weeks after the inspection.

- **Announced inspection:** the service provider will be given at least 4 weeks’ notice of the inspection by letter or email.
- **Unannounced inspection:** the service provider will not be given any advance warning of the inspection.

**Grading**

We grade each service under quality themes and quality statements. We may not assess all quality themes and quality statements.

We grade each heading as follows:

- 6: excellent
- 5: very good
- 4: good
- 3: adequate
- 2: weak
- 1: unsatisfactory

We do not give one overall grade for an inspection.

The quality theme grade is calculated by adding together the grades of each quality statement under the quality theme. Once added together, this number is then divided by the number of statements.
For example:

**Quality Theme 1 – Quality of care and support: 4 - Good**

Quality Statement 1.1 – 3 - Adequate  
Quality Statement 1.2 – 5 - Very good  
Quality Statement 1.5 – 5 - Very good

Add the grades of each quality statement together, making 13. This is then divided by the number of quality statements (there are 3 quality statements), making 4.3. This is rounded down to 4, giving the overall quality theme a grade of 4 - Good.

However, if any quality statement is graded as 1 or 2, then the entire quality theme is graded as 1 or 2 regardless of the grades for the other statements.

**Follow-up activity**

The inspection team will follow up on the progress made by the independent healthcare provider in relation to the implementation of the improvement action plan. Healthcare Improvement Scotland will request an updated action plan 16 weeks after the initial inspection. The inspection team will review the action plan when it is returned and decide if follow up activity is required. The nature of the follow-up activity will be determined by the nature of the risk presented and may involve one or more of the following elements:

- a planned announced or unannounced inspection  
- a planned targeted announced or unannounced follow-up inspection looking at specific areas of concern  
- a meeting (either face to face or via telephone/video conference)  
- a written submission by the service provider on progress with supporting documented evidence, or  
- another intervention deemed appropriate by the inspection team based on the findings of the initial inspection.

A report or letter may be produced depending on the style and findings of the follow-up activity.

More information about Healthcare Improvement Scotland, our inspections and methodology can be found at: [http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_healthcare.aspx](http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_healthcare.aspx)
Appendix 4 – Inspection process flow chart

We follow a number of stages in our inspection process.

**Before inspection**

The independent healthcare service undertakes a self-assessment exercise and submits the outcome to us.

We review the self-assessment submission to help inform and prepare for on-site inspections.

**During inspection**

We arrive at the service and undertake physical inspection.

We have discussions with senior staff and/or operational staff, people who use the service and their carers.

We give feedback to the service’s senior staff.

We undertake further inspection of services if significant concern is identified.

**After inspection**

We publish reports for patients and the public based on what we find during inspections. Healthcare staff can use our reports to find out what other services do well and use this information to help make improvements. Our reports are available on our website at [www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

We require services to develop and then update an improvement action plan to address the requirements and recommendations we make. We check progress against the improvement action plan.
We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille (English only), and
- in community languages.